Teays Valley Child Development Center
6442 Teays Valley Road
Scott Depot, WV 25560
(304)757-9165

APPLICATION FOR ENROLLMENT

Child's Name ______________________________ Birth-date__________________________

Home Address ____

Telephone _________________________ Present age___________ Male/Female (circle one)

Mother's Name _____________________________ Social Security #____________________

Address____

Home Telephone______________________________ Cell/Pager#______________________

Occupation___________________ Employer______________________ Work #___________

Father's Name _____________________________ Social Security #____________________

Address____

Home Telephone______________________________ Cell/Pager#______________________

Occupation___________________ Employer______________________ Work #___________

Custody of Child________________________ Email___________________________________

EMERGENCY CONTACTS

Name____________________________________ Relationship__________________________

Address____ Phone #__________________

Name____________________________________ Relationship__________________________

Address____ Phone #__________________

Child's Physician ______________________________________ Phone #_________________

Physician's Address____

Insurance Co.___________________________________ Policy #_________________________

Preferred hospital where child may be treated:_______________________________________

Names of persons authorized to pick child up from center, including parents/guardian (child will not be allowed to leave with any other person without written authorization from the responsible parent or guardian):

Name____Telephone_________________

Name____Telephone_________________

Name____Telephone_________________

Name____Telephone_________________

Days care is needed: M T W TH F Time of day care is needed: ________________________

CONFIDENTIAL CHILD ASSESSMENT FORM

General Information: Family Name____________________ # of persons in home______

Father______________________ age________ Mother______________________ age______

Marital Status: Married____ Separated____ Divorced____ Widowed____ Other____________

Family and Household:

Children in order of birth (including this child):

Name	Age	Grade in School	Health	Living?
1.				
2.				
3.				
4.				
5.				
6.				

Others in household (show relationship):

Name	Relationship
1.	
2.	
3.	
4.	

HEALTH

Pregnancy and Birth History:

Delivery: Normal_________ Premature_________ (how much)_________ Caesarian_________

Health of Mother during pregnancy____

Complications during pregnancy____

Complication during birth____

Any other pregnancy information that may be helpful _______________________________

GENERAL HEALTH:

Any diseases that 'run' in the family? Yes_____ No_____ If so, describe_________________

____

Is this child subject to:

	OFTEN	SELDOM	NEVER
Colds - upper respiratory infections			
Constipation			
Convulsions			
Diarrhea			
Fever - 103 or above			
Headaches			
Stomach ache			

Operations (give date and description)____

____

Injuries (give date and description)____

____

Describe any difficulties observed with this child's:

Hearing____________________________________ Vision_______________________________

Other____

DEVELOPMENTAL HISTORY (Please submit copy of birth certificate)

Birth weight_________________ Birth-date_________________

Illnesses or complications during newborn period: Yes______ No______ If so, describe_____

____

PAST ILLNESSES: Check those the child has had and give approximate date:

ILLNESS	X	DATE	ILLNESS	X	DATE
Asthma			Mumps		
Chicken Pox			Poliomyelitis		
Diabetes			Rheumatic Fever		
Epilepsy			Rubeola (10 day Measles)		
Hay Fever			Whooping Cough		
Measles (Rubella)			Other		

Is child allergic to any foods? ______ If so, please list:_________________________________

____

Is child allergic to any medications? ______ If so, please list:___________________________

____

Has child ever been separated from parents or guardians for any length of time?___________

____

Describe experiences and the child's reactions and adjustments: _________________________

____

Is there anything in particular that frightens this child? ________________________________

Has this child had any upsetting experiences such as divorce of parents, death in family, frequent or recent moves, etc? ____

____

What were the child's reactions? ____

____

Child's known developmental needs: ____

____

____

ROUTINES

Rating: As a rule, is your child's appetite - good_____, fair_____ or poor_____.

Does he/she eat alone or with the family?___________ Can he/she feed himself completely?_____ List any foods your child is not allowed to eat ________________________

____

Usual meal times: Breakfast_________ Lunch_________ Dinner_________

Sleeping: How many hours does your child sleep at night? _____ Time child gets up in the morning _____ Does child have a bed of their own? _____ Sleeps alone? _____ Takes naps daily? _____ Length of nap _____

Elimination: Training started for bladder control at what age? _____ Bowel control?_____ Is control established in day time?_____ During the night?_____ How does child indicate need for urination?_____ Bowel movement?_____

Self-Help:

CAN CHILD?	**Do Alone**	**Needs Help**	**CAN CHILD?**	**Do Alone**	**Needs Help**
Dress			Comb/brush hair		
Undress			Brush teeth		
Wash hands/face			Tie shoes		
Toilet			Put toys away		

ACTIVITIES

Does your child prefer playing alone? __________ With other children? __________

List names of favorite playmates: ____

Does child get along well with family children? _____ Parents? _____ Other children? _____

Has child attended any children groups? Day Care_____ PreK _____ Sunday School ______

Vacation Bible School_____ Other_______________

Check the approaches to learning your child demonstrates.

	Initative and Curiosity
	Engagement and Persistence
	Reasoning and Problem Solving
	Invention and Imagination
	Other:

Check the methods of control, discipline, teaching you find most effective with this child.

	Bribing		Demonstrating	Other recommended methods:
	Coaxing		Depriving of pleasure	
	Praising		Preparing child in advance	
	Reasoning		Redirection	
	Rewarding		Speaking in a firm voice	
	Time-out		Suggesting	

List any concerns you may have for your child: _______________________________________

____

____

List any goals you may have for your child: ____

____

____

Plan for care when child is ill? ____

Reasons for requesting Center care? ____

____

Does your child attend Church/Sunday School? ________ Where? _______________________

Other information you feel might be helpful in working with your child in the center?

____

____

Permission – (circle one)

I authorize TVCDC to apply sunscreen to my child that I will supply. **Yes No**

I give permission to TVCDC to use video/photographs/audio recordings in school activities, for news, stories, website, or for advertising purposes. **Yes No**

Signature of Parent/Guardian_______________________________________ Date____________

Signature of Director____ Date____________

FOR CENTER USE: Date of Admission________________ Date of Discharge________________